

Absentee Shawnee Tribe of Oklahoma
2025 S. Gordon Cooper
Shawnee, OK 74801
(405) 275 – 4030

Foster Home Applicant - Physical Examination Report

Name: _____ Age: _____ Height: _____ Weight: _____
Address: _____ County: _____

Health History: (Check box to indicate history of any of the following)

- | | | |
|--|---|--|
| <input type="checkbox"/> Convulsive Disorder | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Recent Major Injury or
Operation (specify) _____ |

Result of treatment for any item(s) checked above:

- ☐ Complete Recovery ☐ Partial Recovery ☐ Continued Incapacity

Check block if patient is subject to any of the following symptoms or conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Fainting | <input type="checkbox"/> Orthopedic Handicap |
| <input type="checkbox"/> Asthma, severe | <input type="checkbox"/> Other (specify) _____ | |

PHYSICAL EXAMINATION: (Check block if normal. Explain if any evidence of abnormality)

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Vision _____ | <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Blood Pressure _____ |
| <input type="checkbox"/> Lungs _____ | <input type="checkbox"/> Heart _____ | |

(Attach laboratory reports, as indicated, for tuberculosis, urine, etc.)

General physical condition: _____

Current medications: _____

Over what period of time have you known the patient professionally? _____

Does the patient have any condition that would impair the ability to care for children?

Comment: _____

Examination Date: _____ **Physician:** _____

Address: _____